

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13947

CERTIFICATE OF DEATH

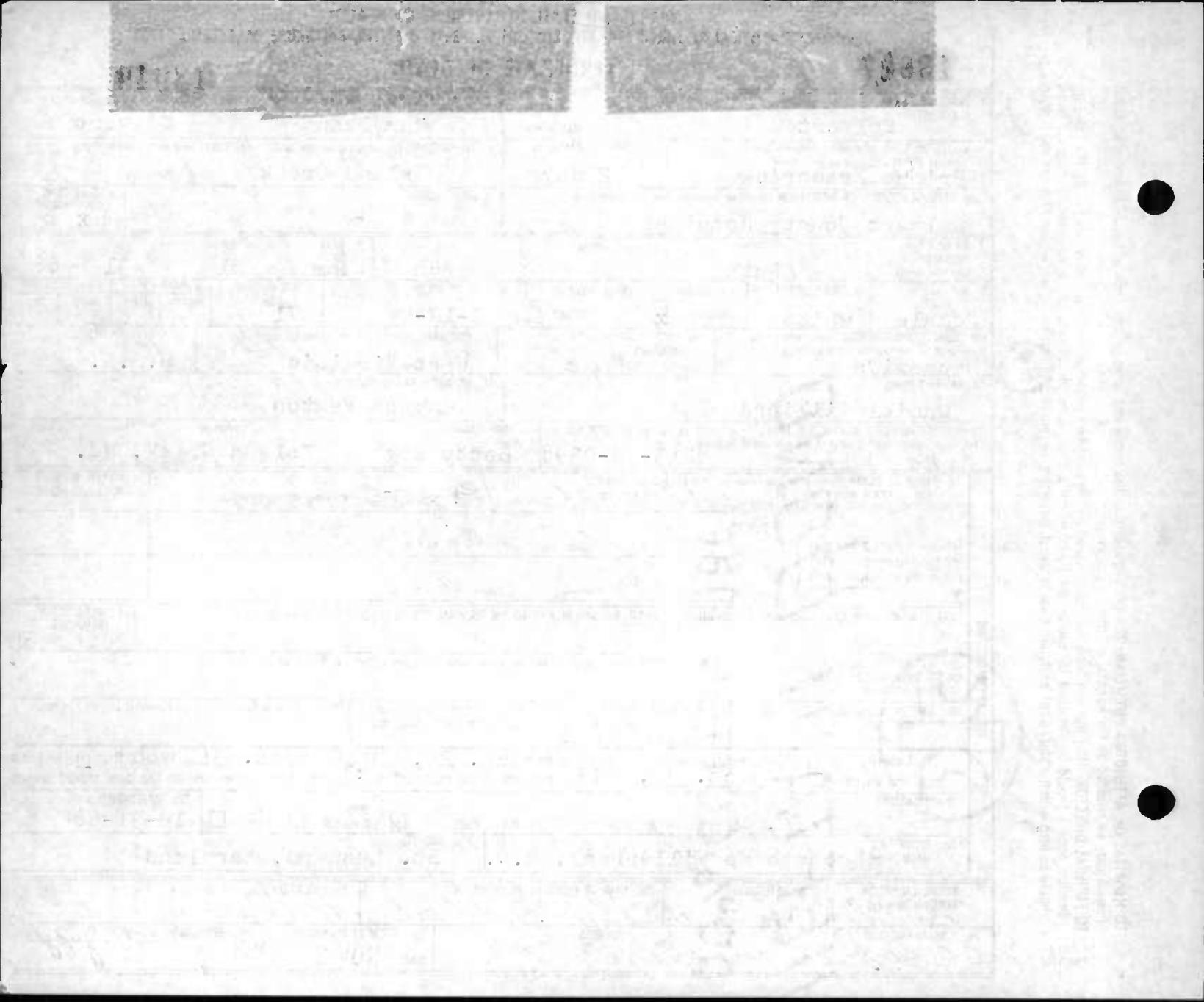
13949

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal from any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Island Creek		(rural) 04-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print)		First Ruth	Middle 	Lost Beach	4. DATE OF DEATH Month 10	Month 31	Doy 19	Year 66
S. SEX female	6. COLOR OR RACE white	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-95	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel Hilliard				14. MOTHER'S MAIDEN NAME Tempest Paxton				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-38-0398		17. INFORMANT Betty Eby		Address Island Creek, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Hemorrhage</u> DUE TO 725X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>- arterio-sclerous</u> DUE TO (c) <u>chemia arterialis</u>								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Oct. 29, 1966 to Oct. 31, 1966, that (I) (we) last saw the deceased alive on Oct. 30, 1966, and that death occurred at 5:30A.M., from causes and on the date stated above.								
22a. SIGNATURE <u>Roberto de Villarreal</u>		22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10-31-66						
22c. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M.D.		22d. ADDRESS St. Leonard, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 2, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Christ Church Cemetery		23d. LOCATION (City or Town) (County) (State) Port Republic, Calvert Co., Md.		
24. FUNERAL DIRECTOR O.O. Harkness, Port Republic, Md.		ADDRESS		25a. RECEIVED BY REGISTRAR NOV 2 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

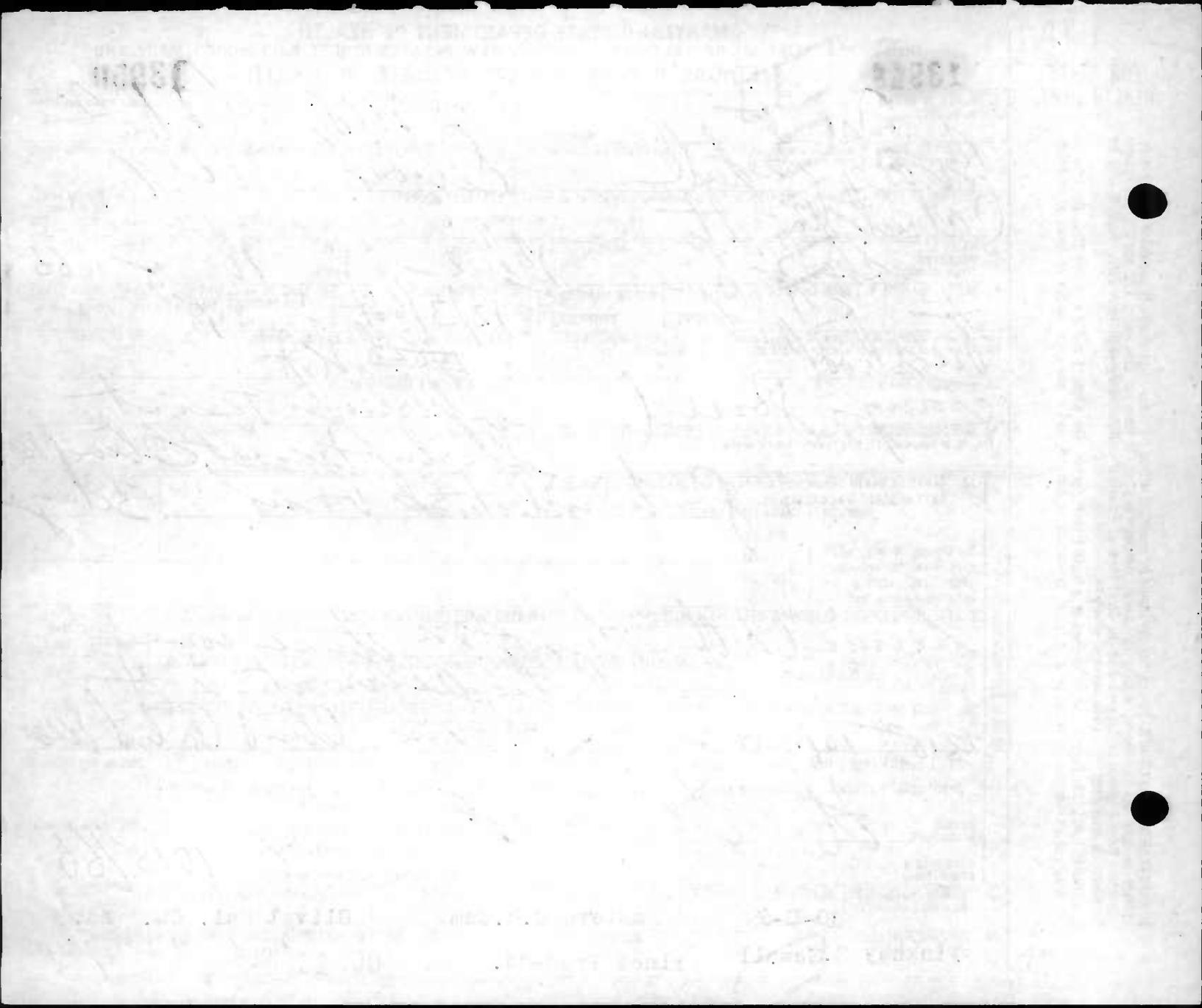
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13948 13951

1. PLACE OF DEATH e. COUNTY <i>Olivet Cal. Co. Md.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olivet Cal. Co. Md.</i>		c. LENGTH OF STAY IN 1b <i>6 months</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Alvarez Hospital</i>		d. STREET ADDRESS <i>Alvarez Hospital</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Sherlyne</i>	Middle <i>Hazel</i>	Last <i>White</i>
4. DATE OF DEATH	Month <i>10</i>	Day <i>8</i>	Year <i>1966</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/3/65</i>
9. AGE (In years last birthday) yrs. <i>21</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Michigan</i>	12. CITIZEN OF WHAT COUNTRY? <i>United States</i>
13. FATHER'S NAME <i>Jerry Donald</i>	14. MOTHER'S MAIDEN NAME <i>Herleen Kent</i>	Address <i>1100 Maryland Avenue, Olney</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Herleen Kent, Olney</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5710</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Deemed better than at home some</i> <i>and dependent on H</i> DUE TO DUE TO			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Due to personal care of H</i>		
20c. TIME OF INJURY Month, Day, Year Hour p.m. <i>12/18 10/8/66 1966</i>	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At home</i>	20f. (City or town) (County) (State) <i>Olivet Cal. Co. Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <i>Charles Judge</i>			
22. DATE SIGNED <i>10/8/66</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE THEREOF <i>10-11-66</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Eastern C.h.Cem</i>	23d. LOCATION (City, town or county) (State) <i>Olivet Cal. Co. Md.</i>
24. FUNERAL DIRECTOR <i>Pinkney E. Sewell</i>	ADDRESS <i>Prince Fred-Md.</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



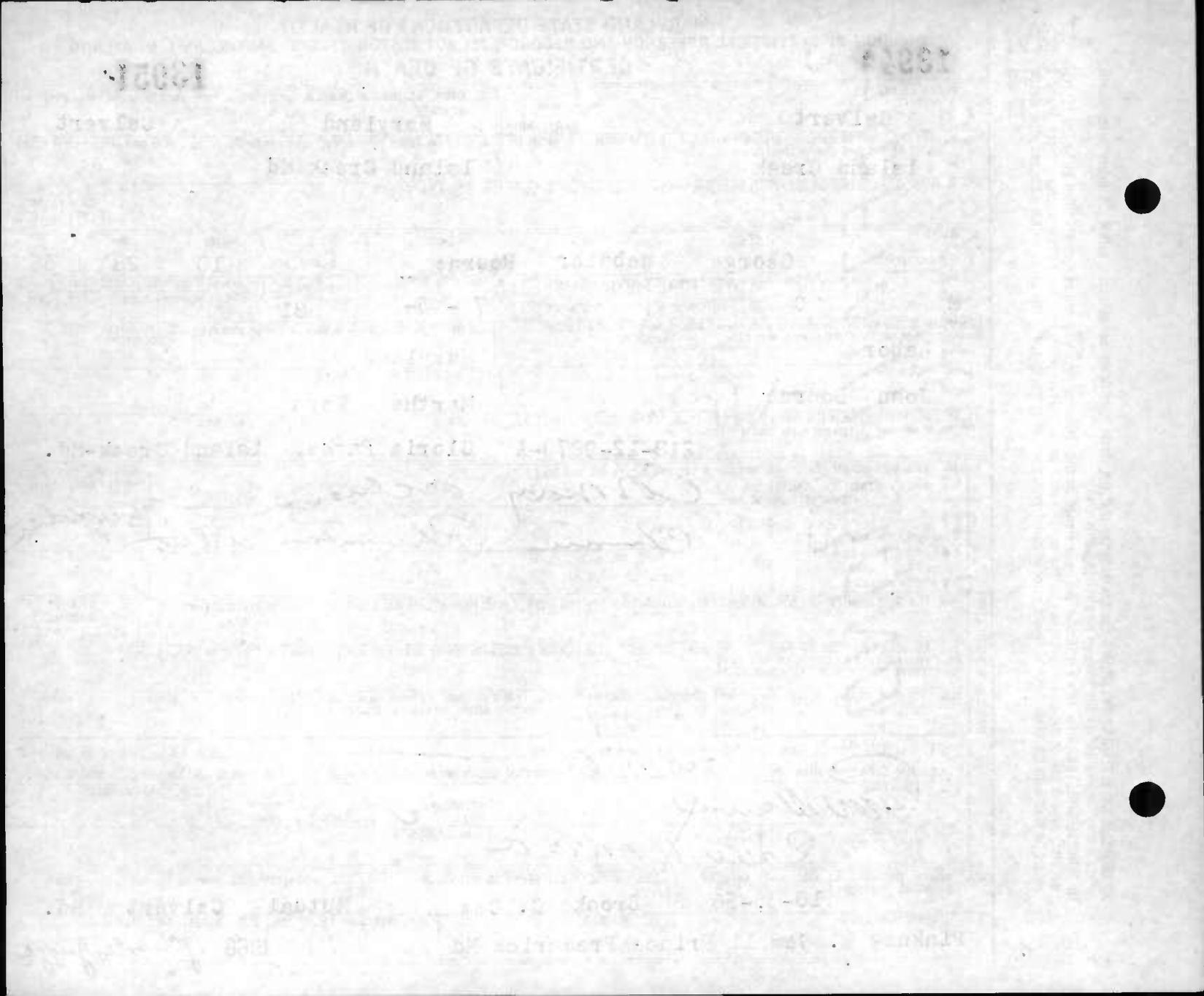
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13951

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH														
		13951														
		1. PLACE OF DEATH a. COUNTY Calvert MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert										
		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Island Creek		c. LENGTH OF STAY IN 1b 00		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Island Creek Md		d. STREET ADDRESS 00		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
		3. NAME OF DECEASED First Middle Last George Webster Bourne			4. DATE OF DEATH Month Day Year 10 28 19 66											
		5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ODIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 - 3 -	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.								
		11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor			11b. KIND OF BUSINESS OR INDUSTRY 			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? 					
		13. FATHER'S NAME John Bourne			14. MOTHER'S MAIDEN NAME Martha Keys			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 			16. SOCIAL SECURITY NO. 218-17-9279-A			17. INFORMANT Gloria Parker Address Island Creek-Md.		
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Rheumatism arthritis Due to (c) Sudden														
		INTERVAL BETWEEN ONSET AND DEATH														
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		
		20f. (City or town) (County) (State)														
		21. I certify that (I) (this hospital) attended the deceased from <u>8/30/66</u>, to <u>19</u>, that (I) (we) last saw the deceased alive on <u>8/30/66</u>, and that death occurred at <u>8:30 AM</u>, from the causes and on the date stated above.														
		22a. SIGNATURE <i>John Sewell</i>														
		22b. DATE SIGNED <i>8/30/66</i>														
		22c. PHYSICIAN'S NAME (Type) <i>R. E. Sewell</i>														
		23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 10-30-66			23c. NAME OF CEMETERY OR CREMATORIUM Brooks C. Cem			23d. LOCATION (City, town or county) Mutual			(State) Calvert Md.					
		24. FUNERAL DIRECTOR Pinkney E. Sewell Prince Frederick-Md.			AOORESS			25a. REC'D BY REGISTRAR NOV 1			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					
		VR A15 (4) 2DM 1/65														



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13950

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. If either, notify medical examiner. This certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Calvert		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN lb 7 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Olive	Middle Reed	Last Bowen
4. DATE OF DEATH	Month 10	Day 10	Year 1966
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-28-91		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Calvert County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Jones		14. MOTHER'S MAIDEN NAME Elizabeth Wilkerson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. 216-18-5667	
17. INFORMANT Elizabeth Stuart Chesapeake Beach, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 442x		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		(d) DUE TO (e) DUE TO (f)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (This hospital) attended the deceased from Oct. 3, 1966 , to Oct. 10, 1966 , that (I) (we) lost saw the deceased alive on Oct. 10, 1966 , and that death occurred at 7:00 PM , from causes and on the date stated above.			
22a. SIGNATURE G.J. Weems		22b. DATE SIGNED Oct. 11, 1966	
22c. PHYSICIAN'S NAME (Type) George J. Weems, M.D.		22d. ADDRESS Huntingtown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 13, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL Lower Marlboro Chr. Cem.		23d. LOCATION (City or Town) (County) (State) Lower Marlboro Cal. Co. Md.	
24. FUNERAL DIRECTOR Hutchins Funeral Home Owings Mill		ADDRESS	
		25a. REC'D BY REGISTRAR OCT 13 1956	25b. REGISTRAR'S SIGNATURE Charles Juge

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17/10/32 5:00 P.M.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 32 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Solomons		d. STREET ADDRESS —		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First John	Middle Winfield	Last Brooks	4. DATE OF DEATH October 22 1966	Month Oct	Doy 22	Year 1966
S. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-20-77	9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Waterman		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Winfield Brooks		14. MOTHER'S MAIDEN NAME ? Parker						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. 217-18-9847		17. INFORMANT Nancy Dolan - Solomons, Maryland		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion						INTERVAL BETWEEN ONSET AND DEATH		
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		DUE TO Due to General circulatory disease						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to 10/22/66 , that (I) (we) last saw the deceased alive on 19_____ , and that death occurred at M. from causes and on the date stated above.								
22. SIGNATURE John Winfield Brooks				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/25/66		
22c. PHYSICIAN'S NAME (Type) R. De Villiers Brooks		22d. ADDRESS St. Leonard, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Solomons Methodist Cemetery		23d. LOCATION (City or Town) (County) (State) Solomons Calvert Md.		
24. FUNERAL DIRECTOR A. A. Mackenae & Son - Port Republic, Md.		ADDRESS Market Bay 34		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13952

CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or attending physician.****10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Calvert MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	c. LENGTH OF STAY IN lb 46 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Warren	Middle	Last Brown
4. DATE OF DEATH	Month October	Day 2	Year 1966
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/94
9. AGE (In years last birthday) yrs. 71	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Brown	14. MOTHER'S MAIDEN NAME Alice Coates		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO. 217-26-4025	17. INFORMANT Kizzie Jones - Daughter	Address Huntingtown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Malnutrition</i> 151X Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause (b) <i>Ca of Stomach</i> DUE TO stating the underlying cause (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 19 <i>66</i> , to <i>Oct 2 - 66</i> , that (I) (we) last saw the deceased alive on <i>19</i> and that death occurred at <i>Huntingtown</i> , Md., from causes and on the date stated above.			
22a. SIGNATURE <i>John Leonard</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Roberto deVillarreal		22d. ADDRESS St. Leonard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10-4-66	23c. NAME OF CEMETERY OR CREMATORIAL Potowmack C. Cem.	23d. LOCATION (City or Town) (County) (State) Huntingtown, Md.
24. FUNERAL DIRECTOR Linckley E. Sewell Jr., Frederick, Md.		ADDRESS	25a. REC'D BY REGISTRAR Charles Judge
		DATE OCT 7 1966	25b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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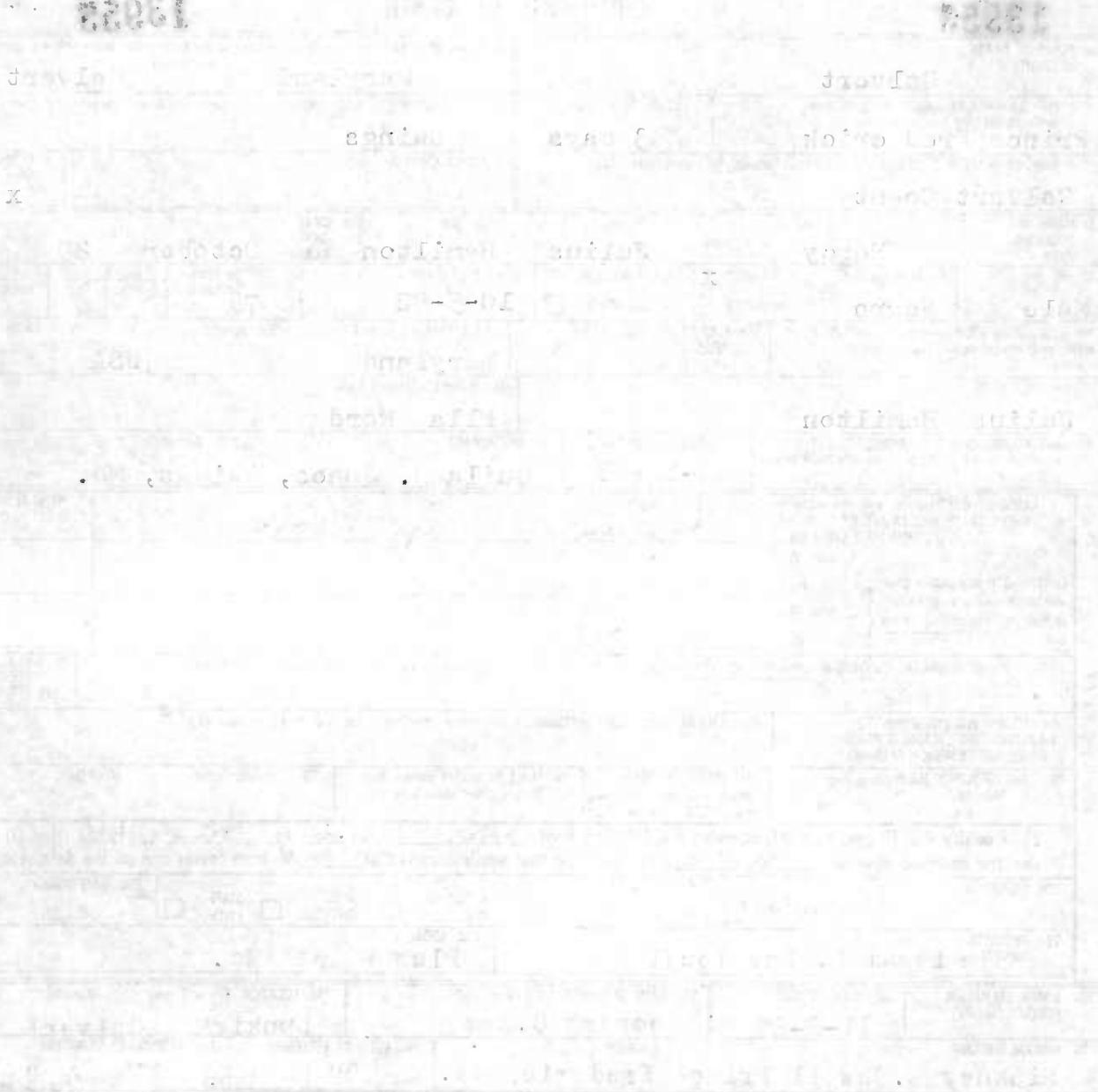
CERTIFICATE OF DEATH

13955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Fred erick		c. LENGTH OF STAY IN lb 3 days		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert County		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Percy		First Julius	Middle Hamilton	
4. DATE OF DEATH October 29 1966		Month	Day Year	
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input type="checkbox"/> X NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-5-92	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 74 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME Julius Hamilton		14. MOTHER'S MAIDEN NAME Ella Ford		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 214-12112A	17. INFORMANT Address Guila G. Jones, Owings, Md.	
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1810 DUE TO Carcinoma of Bladder INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) DUE TO Meiosis . (c) DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Dunkirk (County) Calvert (State) Md.
21. I certify that (I) (this hospital) attended the deceased from Sept. 1966 , to Oct. 25, 1966 , that (I) (we) last saw the deceased alive on 11 P.M. 1966 , and that death occurred at 7 A.M. from causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
22a. SIGNATURE Issam F. Damalouji		22b. DATE SIGNED 11-2-66		
22c. PHYSICIAN'S NAME (Type) Issam F. Damalouji		22d. ADDRESS Plum Point Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Coopers C.Cem		23b. DATE THEREOF 11-2-66		23d. LOCATION (City or Town) (County) (State) Dunkirk Calvert Md.
24. FUNERAL DIRECTOR Pinkney E. Sewell Prince Frederick-Md.		ADDRESS		25a. REC'D BY REGISTRAR NOV 1 1966
				25b. REGISTRAR'S SIGNATURE Charles Judge



FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
13954				13956							
1. PLACE OF DEATH e. COUNTY <i>Calvert</i> MARYLAND <i>Lake Malloway</i>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Calvert</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dunwoody</i>				c. LENGTH OF STAY IN 1b <i>04/04/1</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i></i>				d. STREET ADDRESS <i></i>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Hyde Elmer Harris</i>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	23	1966	
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 13 1951</i>	9. AGE (in years last birthday) <i>15 yrs.</i>	IF UNDER 1 YEAR <input type="checkbox"/>	IF UNDER 24 HRS <input type="checkbox"/>	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sailor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i></i>				11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md.</i>			
13. FATHER'S NAME <i>Hyde W. Harris</i>				14. MOTHER'S MAIDEN NAME <i>Eveline Chase</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <i></i>				17. INFORMANT <i>Hyde W. Harris</i> Address <i>Oceanview</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>9298</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fell over board, and fell away</i>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Walked to Calm</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year <i>5:30 a.m. 10/23/66</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Lake Malloway Calvert Co.</i> (City or town) <i>Lake Malloway</i> (County) <i>Calvert Co.</i> (State) <i>Md.</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>H. W. Ward</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED <i>10/23/66</i>			
EXAMINER'S NAME (Type) <i></i>				M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				Address (Street, city, town or county) <i></i>			
23a. BURIAL, CREMATION, EMBALMING (Specify) <i>Burial</i>				23b. DATE THEREOF <i>10-27-66</i>				23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Johns Church Cemetery</i>			
24. FUNERAL DIRECTOR <i>Leroy E. Berry Huntington</i>				ADDRESS <i>1617</i>				REC'D BY REGISTRAR <i>1617</i>			
VR A15ME 3500 4-64				DATE <i>OCT 35 1966</i>				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY Calvert				a. STATE Maryland											
b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick				b. COUNTY Calvert											
c. LENGTH OF STAY IN lb 95 days				c. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) Olivet											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert County Hospital				d. STREET ADDRESS —											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) Nettie Johnson				First Nettie	Middle Isabelle	Last Johnson	4. DATE OF DEATH October 30 1966	Month October	Day 30	Year 1966					
5. SEX Female				6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 5-24-87	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months —	IF UNDER 24 HRS. Days —	Hours —	Min. —				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Thomas Grover				14. MOTHER'S MAIDEN NAME Sarah Elizabeth Tall											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-07-8980				17. INFORMANT Mrs. Esther Tall, Olivet, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Due to an coronary artery occlusion				INTERVAL BETWEEN ONSET AND DEATH —											
(b) Due to an coronary artery occlusion															
(c) Due to an coronary artery occlusion															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 107 6th Street				20f. (City or town) —		(County) —	(State) —
21. I certify that (I) (this hospital) attended the deceased from Oct 30 1966 , to Oct 30 1966 , that (I) (we) last saw the deceased alive on Oct 30 1966 , and that death occurred at M , from the causes and on the date stated above.															
22a. SIGNATURE William J. De Villarcon				22b. DATE SIGNED Nov 2 1966											
22c. PHYSICIAN'S NAME (Type) R. J. De Villarcon				22d. ADDRESS St. James											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov 1, 1966				23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery				23d. LOCATION (City, town or county) Luthy, Charles, Md.			
24. FUNERAL DIRECTOR R. A. Hendren & Son, Port Republic, Md.				25a. REC'D BY REGISTRAR Charles Judge								25b. REGISTRAR'S SIGNATURE			
				DATE NOV 2 1966											

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13956

CERTIFICATE OF DEATH

13958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
Calvert MARYLAND		Maryland Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Solomons, Prince George's		Live 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
Calvert County Hospital		Solomons	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
		Clifford	James
4. DATE OF DEATH		Month	Day Year
		10	24 1966
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
		8/28/87	79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired		Waterman	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Calvert Co., Maryland		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William J. Lusby		Sewell Coster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Address	
No		219-16-0990A Mrs. Etta Mae Jenkins, Staten Island, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Eczema	
177X			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Cayenne (c) pap. Sore	
DUE TO (b)			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 7-33-67, 1967 to 10-24-66, 1966, that (I) (we) last saw the deceased alive on 10-24-1966, and that death occurred at 10:20 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 10-25-66	
22a. SIGNATURE <i>Weems</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) G.J. Weems		22d. ADDRESS no Huntington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 27, 1966	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Solomons Methodist Cemetery Met. West Box 34
24. FUNERAL DIRECTOR A.A. Harkness & Son Post Republic, Md.		23d. LOCATION (City, town or county) Solomons Calvert Co. Md.	25a. REG'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge
		DATE OCT 27 1966	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
MEDICAL EXAMINER'S CERTIFICATE OF DEATH														
13957		13960												
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE b. COUNTY												
Calvert		Md. Calvert												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Prince Frederick												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS												
Calvert Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year						
Mamie Etta Mackall Reed					10	10	13	1966						
5. SEX		6. COLOR OR RACE	7. MARRIED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.						
F		C	<input type="checkbox"/> WIDOWED	<input checked="" type="checkbox"/> DIVORCED	10/10/11	55 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?							
Homemaker				Md.										
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address										
Hardy Mackall		Rose Mackall		Mable Hawkins-Dunkirk - Md.										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH								
(No)		220-381462		Mable Hawkins-Dunkirk - Md.		2 hrs.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)														
7824														
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.														
DUE TO														
(b)														
DUE TO														
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
Began to cough and died before got to hospital														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour, Min.		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2f. (City or town)		(County)		(State)				
1205 AM 10/10/66		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Home		Dundland		Md.		Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>H.W. Ward</i>														
EXAMINER'S NAME (Type)														
CHIEF MEDICAL EXAMINER <input type="checkbox"/>														
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>														
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>														
Address (Street, city, town, or county)														
22. DATE SIGNED <i>10/13/66</i>														
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)		(State)						
REMOVAL (Specify)		11-16-66		Patuxent C. Cem.		Patuxent Cal. Co. Md.								
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Pinkney E. Sewell Prince Frederick, Md.				DATE OCT 18 1966		<i>Charles Judge</i>								

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13958

CERTIFICATE OF DEATH

13959

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.**Page 4 may be retained by the hospital or offending physician.****TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-trousser permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

II. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown (Crab)</i>		c. LENGTH OF STAY IN 1b <i>6 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>-</i>				d. STREET ADDRESS <i>Need Estate</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <i>August</i>	Middle. <i>William</i>	Last <i>Newland</i>	4. DATE OF DEATH <i>Oct.</i>	Month <i>6</i>	Day Year <i>1966</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>Aug. 5 1908</i>	9. AGE (In years last birthday) <i>58 yrs.</i>	IF UNDER 1 YEAR Months <i>58</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bakery</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>August William Newland Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Theresa Haumbach</i>		Address <i>Mrs. Gertrude Newland, Huntingtown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-48-0635</i>		17. INFORMANT <i>Mrs. Gertrude Newland, Huntingtown</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Excessive Cerebrum of</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>161X</i>		DUE TO (b) <i>Lung - with metastasis.</i>		DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i></i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1962</i> , 19, to <i>1966</i> , 19, that (I) (we) last saw the deceased alive on <i>10-1-1966</i> , and that death occurred at <i>10A.M.</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Tawley</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Issam F. Damalouji M.D.</i>		22d. ADDRESS <i>Prince Frederick Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE THEREOF <i>5th Oct 8, 1966</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Burhady Star of the Sea</i>		23d. LOCATION (City or Town) (County) (State) <i>Solomons, Calvert, Md.</i>	
24. FUNERAL DIRECTOR <i>A. A. Harkness & Son</i>		ADDRESS <i>Mt. Holly Public, Md.</i>		25a. REC'D BY REGISTRAR <i>J. Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>OCT 10 1966</i>	

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1 M

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

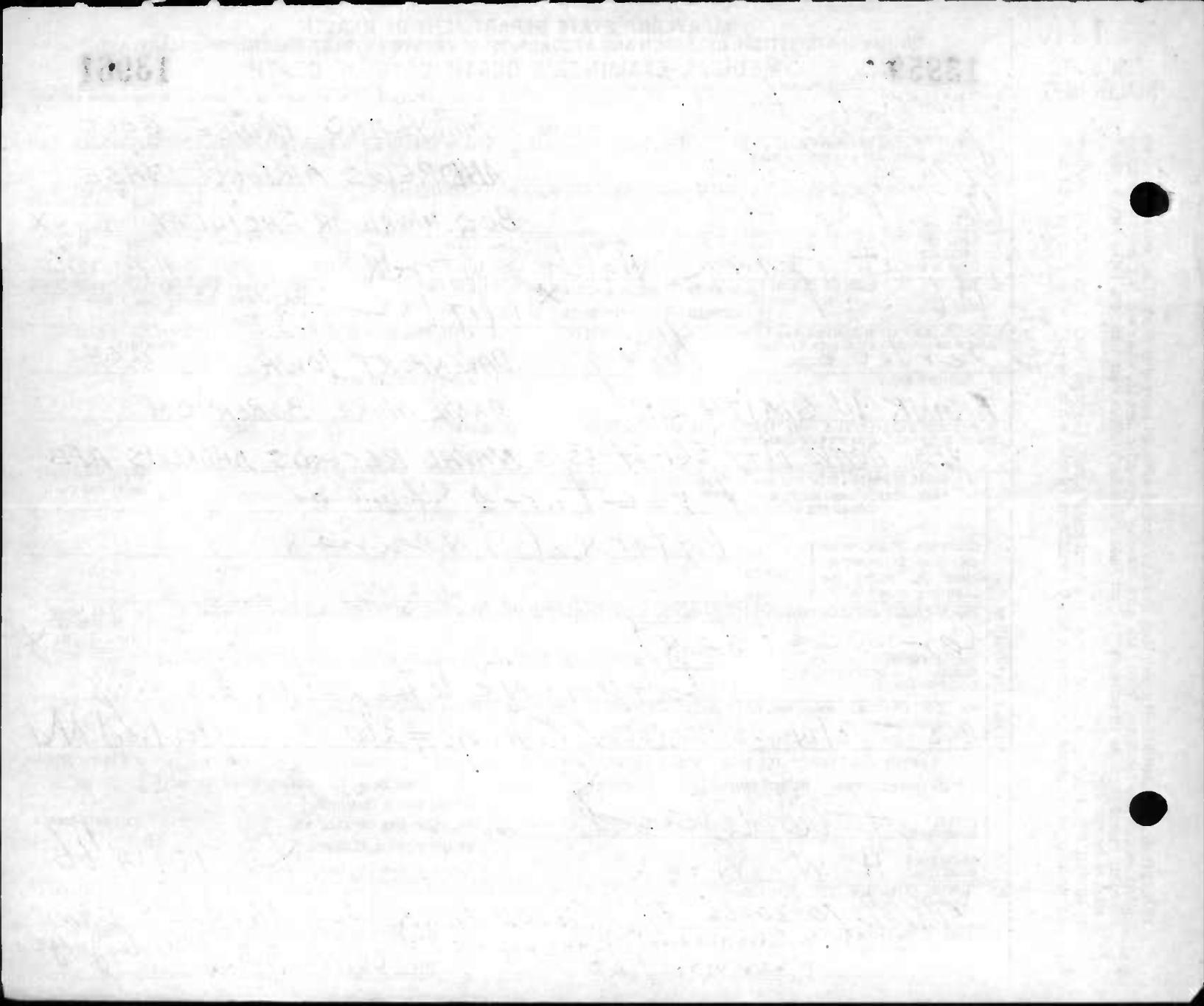
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13959

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
<i>Calvert Co</i>		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		<i>MARYLAND PRINCE GEORGE'S</i>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<i>ANDREWS AIRFORCE BASE</i>	
e. STREET ADDRESS		d. STREET ADDRESS	
<i>Calvert Co MD</i>		<i>BOQ. NAVAL AIR FACILITY</i>	
f. NAME OF DECEASED (Type or print)		Last	DATE OF DEATH
g. SEX		Middle	Month
h. COLOR OR RACE		First	Day
i. MARRIED		NEVER MARRIED	Year
j. WIDOWED		DIVORCED	10 14 66
k. DATE OF BIRTH		9. AGE (In years last birthday)	l. IF UNOER 1 YEAR
11/17/32		33 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
<i>Service</i>		<i>DAVENPORT IOWA</i>	
12. CITIZEN OF WHAT COUNTRY?		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>FRANK W SMITH SR</i>		<i>ANNIE MARIE BOBERICH</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
YES ACTIVE DUTY		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e)		<i>Fractured skull & internal injuries</i>	
8234			
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		DUE TO	
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Car accident		21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> p.m. 10/14/66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Calvert Md</i>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		M.O. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-20-66</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>INGLEWOOD PARK</i>	
24. FUNERAL DIRECTOR <i>W. W. Chambers Co</i>		23d. LOCATION (City, town or county) (State) <i>LOS ANGELES CALIF.</i>	
ADDRESS <i>1400 Chapin St NW Washington, D.C.</i>		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 13 1966</i>	



1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

2 To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and return within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 11,12 Film G382 11/15/66 mh

13960

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13962

1. PLACE OF DEATH o. COUNTY CALVERT		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND North Carolina	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE BEACH		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 808 W. Airline Avenue	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAJORIE		First Summy	Middle STROUPE
4. DATE OF DEATH October 27 1966		Month October	Day 27
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH 6/10/1909		9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Ware Shoals, South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Tess William Summy		14. MOTHER'S MAIDEN NAME Willie Reid	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Carothers F. Hme. Gastonia, N.C.	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular 443X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Gastonia (County) N.C. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED October 28, 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/30/66	23c. NAME OF CEMETERY OR CREMATORIUM Gaston Memorial Pk. Gastonia, N.C.
23d. LOCATION (City or Town) Gastonia (County) N.C. (State)			
24. FUNERAL DIRECTOR James M. Fields 4481 Bonnie Brae Rd.		ADDRESS Baltimore, Md.	25a. REC'D BY REGISTRAR NOV 1 1966
			25b. REGISTRAR'S SIGNATURE Charles Judge

173

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1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13961

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13963

1. PLACE OF DEATH a. COUNTY Calvert County		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		b. COUNTY Calvert	
c. LENGTH OF STAY IN 1b 15		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First James	Middle Edward
4. DATE OF DEATH		Month 10	Day 9
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-3-51		9. AGE (in years last birthday) 15 yrs.	10. FUNERAL 1 YEAR Months Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		11. BIRTHPLACE (State or foreign country) Calvert County, Md.	
12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME James Edward Wallace, Sr.	
14. MOTHER'S MAIDEN NAME Olive Jacks		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. XXXXXKXKX		17. INFORMANT Note Mr. James Edward Wallace Sr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9298 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH DROWNING	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) DOD
20f. (City or town) DOD		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>J. Wallace</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>J. Wallace</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-13-66	23c. NAME OF CEMETERY OR CREMATORIAL Calvary United Church Sunderland, Md.
24. FUNERAL DIRECTOR Leroy E. Berry-Huntingtown		ADDRESS N/A	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge
DATE OCT 11 1966			

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